RAI PATIENT HISTORY MRI EXTREMITY: **Technologist/Tech Aide:**___________________________

Today's Date:___________________________ **Patient Scanned for Metal:** ☐ **Yes** ☐ **No** **RAI Tech:**_________________

Name: ______________________________________Age: ____ Weight: ____ Referring Physician: ______________________________

1. What part of the body will be scanned today:____

2. Describe your current problems/symptoms:____

____

A. Length of symptoms:_________**B**. Which side of your body? (Circle One) Right Left Bilateral (Right and Left)

3. Have you had an injection in this part of your body? Yes - No Type? ____

4. Any **surgery** or **arthroscopy** on area being scanned: Circle: Y – N Type?_____________________When?_____________________

5. Any prior joint replacement or hardware?_____________ If so, what type ____

6. If Injury/Accident/MVA –

a. Exact Location (ex. Muscle, bone): ____

b. Type of Injury/Symptoms (Circle One): 1. Abrasion 2. Contusion 3. Laceration/Open Wound 4. Penetrating 5. Sprain

6. Foreign Body 7. Swelling 8. Other____

c. Which side of your body? (Circle One): Right Left Bilateral (Right and Left)

7. Do you have a history of bone cancer? Circle: Y - N Type? ____

8. Treatments related to bone cancer:

Chemo – if yes, date of last treatment__________________ provide date of any future treatments planned __________________

Radiation – if yes, date of last treatment__________________ provide date of any future treatments planned ________________

Other treatment – please describe and provide dates: ____

9. Describe any existing medical conditions (high blood pressure, diabetes):

____

10. List ALL current medications: ____

11. Do you have any known allergies:____

12. **Prior Diagnostic Imaging: Extremity Studies (XRAY/MR/CT):**

Study/Date/Facility:____

____

13. Have you experienced any problem related to a previous MR examination or MR procedure? Yes - No

If yes, please describe: ____

14. Have you had an injury to the eye involving a metallic object or fragment (i.e.; metallic slivers, shavings, foreign body, etc.)?

Yes – No If yes, please describe: ____

15. Have you ever been injured by a metallic object or foreign body (i.e.; BB, bullet, shrapnel, etc.)? Yes - No

If yes, please describe: ____

16. Has your physician prescribed any sedation or medication specifically for this examination? Yes - No

If yes, please indicate type and amount____

17. FOR FEMALE PATIENTS:

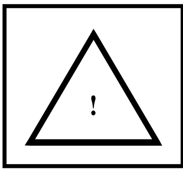
1. Date of last menstrual period: ___________________________________ Post-menopausal? Yes - No (Circle which apply)
2. Are you pregnant or experiencing a late menstrual period?____________________________ Yes - No

Comments:____

____

____

____ (see back of form)

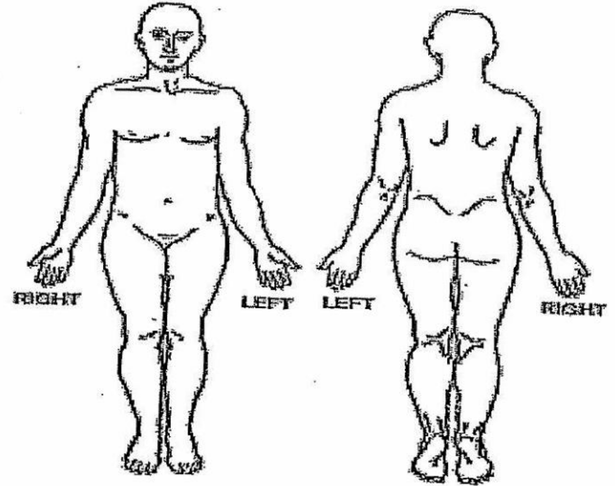


WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure (i.e. MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room.
The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- ☐ Yes ☐ No Aneurysm clip(s)
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
- ☐ Yes ☐ No Electronic implant or device
- ☐ Yes ☐ No Magnetically-activated implant or device
- ☐ Yes ☐ No Neurostimulation system
- ☐ Yes ☐ No Spinal cord stimulator
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Bone growth/bone fusion stimulator
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
- ☐ Yes ☐ No Heart valve prosthesis
- ☐ Yes ☐ No Eyelid spring or wire
- ☐ Yes ☐ No Artificial or prosthetic limb
- ☐ Yes ☐ No Metallic stent, filter, or coil
- ☐ Yes ☐ No Shunt (spinal or intraventricular)
- ☐ Yes ☐ No Vascular access port and/or catheter
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Swan-Ganz or thermodilutin catheter
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine, birth control)
- ☐ Yes ☐ No Any metallic fragment or foreign body (bullet, pellets, shrapnel)
- ☐ Yes ☐ No Any wire mesh implant
- ☐ Yes ☐ No Tissue expander (e.g., breast)
- ☐ Yes ☐ No Surgical staples, clips, or metallic sutures
- ☐ Yes ☐ No Joint replacement (hip, knee, etc.)
- ☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
- ☐ Yes ☐ No IUD, diaphragm, or pessary
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Tattoo or permanent makeup
- ☐ Yes ☐ No Body piercing jewelry
- ☐ Yes ☐ No Hearing aid *(Remove before entering the MR system room)*
- ☐ Yes ☐ No Other implant________________
- ☐ Yes ☐ No Breathing problem or motion disorder
- ☐ Yes ☐ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of OR on your body.



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IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise. MRI is generally a safe procedure. Qualified medical personnel will be present throughout the entire procedure. The FDA has determined that MRI presents no great risk.

I attest that all information provided is correct to the best of my knowledge and that I will not bring any type of metallic objects into the MRI room including but not limited to hearing aids, weapons, watches, electronics, etc. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. I understand I cannot hold Radiology Affiliates liable for injury or loss of personal property due to my own negligence.

Signature of Person Completing Form:____ Date:____________________________

Form Completed By: ☐ Patient ☐ Relative ☐ Other_____________________________ ________________________________
Print name — Relationship to Patient

Form Information Verified by:____ ________________________________
Print name — Signature